DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

SURVEYOR NOTES WORKSHEET

Facility Name: ____

Surveyor Name: ______________________________ Surveyor Number: ________________

Provider Number: ____________________________ Discipline: ____________________

Observation Dates: From ________________ (mm/dd/yyyy) To: ________________ (mm/dd/yyyy)

TAG/CONCERNS	DOCUMENTATION

SURVEYOR NOTES WORKSHEET

TAG/CONCERNS	DOCUMENTATION